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Review Article

Depression, Diagnostic Criteria, Explanatory Theories and Current Treatment Efficacy Compared

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ABSTRACT

In the present, the nosological characterization of depression is approached, as an entity susceptible to clinical diagnosis, the semiotics of its symptomatological manifestations and pathognomonic signs are described, according to standardized criteria, to then illustrate the underlying processes that, according to different models explanatory, cognitive, and behavioral, account; of the genesis, development, and feedback mechanisms and maintenance of depressive clinical symptoms. Finally, a screening of controlled clinical trials is carried out, with treatment and control groups, where the variable to be measured was the differences or not, in the therapeutic results between cognitive and pharmacological treatment modalities of depression, regarding the prolongation of the effect, relapses and comparative improvement rates.

Keywords: Major depression; Cognitive behavioral models; Psychopharmacology; Clinical trials

INTRODUCTION

Cognitive Behavioral Therapy (CBT) has proven to be effective in the treatment of acute depression, currently positioning itself as an alternative treatment to pharmacotherapy, with results confirmed by randomized studies, with control groups and simultaneously compared with the simultaneous application of medications [1]. This is especially true for unipolar depression, placing CBT as a useful complement in the comprehensive formulation of mixed treatments. It is also corroborated, in longitudinal lines of studies, with outpatients, contacted through primary care centers, and to whom the patient is followed after the end of therapy, that the results are sustained or prolonged in time, which indicates positive impacts at the prophylactic level against new relapses, in which CBT exceeds the management of depression with antidepressants, serotonin receptor inhibitors and tricyclic antidepressants.

In clinical trials, with rigorous treatment protocols, in controlled environments according to randomized drug dose guidelines vs. placebo, the therapeutic effects or benefits at the symptomatic level of these drugs have a short life span, once suspended or interrupted, the Frequent relapses are usually one of its greatest disadvantages, on the other hand, the levels of tolerability to its side effects vary from patient to patient, this being one of the main reasons why patients do not continue or do not adhere to treatment protocols. Serotonin Reuptake Inhibitor (SSRI) drugs of the first line of care, commonly are escitalopram, sertraline, being already second choice; mirtazapine and bupropion [2].

CBT, by equipping the patient with coping strategies in the future, in the face of adverse events, or events of considerable impact at the level of the development life cycle, is one of the strong factors, with multiple advantages compared to other types of treatments. In addition, it is verified that changes in cognition have an impact on basic neurobiological substrates, thus modifying, not only, preventive behavioral responses and future risk reduction, but also, producing changes at the level of emotional, cognitive and emotional disposition. Affective modulation, facing life problems [3,4].

DEPRESSION IN STATISTICS

Throughout life, 16.3% of the current population will have at least one depressive episode, at some point in their life, three-quarters of these patients will repeat this episode, at least once in their life, a A third will suffer episodes that last for periods of time greater than two years, with the aggravation that a large percentage do not receive it, and among those who receive it, not all respond to the different possible intervention modalities [5]. On the other hand, the rates of comorbidity with other disorders are high, with marked deterioration in multiple areas of functioning, a tendency to chronicity, incapacity for work and high monetary losses, and the risk of suicide is widely raised [6,7].

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The global prevalence of depression is estimated according to variability by sex, at 20% in women, and half of this percentage (10%) in men, that is, for every three people who show depression, two will be women for every man, with a hereditary component that could explain up to 25% of the occurrence of the disorder in moderate-mild cases, and up to 50% for severe cases [8]. An estimated 322 million people affected by depression, the probability of chronicity, once the first episode is had is 30%, with the age group ranging between 15 and 29 years old being the most affected, 788,000 people each. Year, they are victims of suicide attributable to depression, according to the World Health Organization.

Colombia is the eighth country in Latin America with the highest rates of depression. The Sub-Directorate of Non-communicable Diseases, in the March 2017 bulletin, shows that the prevalence of depression has been increasing in Colombia. In the period 2009-2015, statistical data from the winery records of the Comprehensive Social Protection Information System and individual records for the provision of services (RIPS) show that in 2015 of the total number of people treated for a case of moderate depression, 70.4% were women compared to 29.6% men, for a total of 36,236 people. As of 2018, the depression figures in Colombia are 4.7%, exceeding the world average of 4.4%. When the data are disaggregated by territory, the department of Antioquia occupies the first places, comparing it with the figures reported in other departments.

The Mental Health Observatory, of the Ministry of Health and Social Protection (2018), in its annual report of mental health indicators for the city of Medellín, capital of the department of Antioquia, in 2017, shows a figure of 35,237 people attended by mood disorders (affective), which corresponds to 1.95%. Of the total number of services reported by the health system.

DEPRESSION IN DSM-IV; DSM-5 AND ICD-10

As far as its definition is concerned, depression is both a syndrome and a disorder, as a syndrome, it is a conglomeration of heterogeneous symptoms in its presentation, which is composed of expressions of variable range of periods of sadness, loss of motivation, manifested as a lack of energy, discouraging attitude towards what may happen in the future, deeply rooted beliefs, self-denigrating in relation to the self-concept and an image whose framework in general negatively evaluates the self, lethargic behavior, with visible loss of vitality, noticeable both to the patient and to those around him, suicidal thoughts, vision of hopelessness, and reduced self-efficacy, alterations in the sleep process, changes in appetite and previous sexual desire [9].

Regarding disorder, according to the Statistical Diagnostic Manual of Mental Disorders, Revised Version IV (DSM IV; T-R), depression takes two classic forms of presentation; a so-called unipolar, whose distinctive feature is the emotional affectation always in the direction of sadness and negative general mood, characteristically depressive. The bipolar form, on the other hand, gives rise to a marked euphoria, episodes of exaltation of the mood, which may be accompanied by risky or reckless behaviors that put the patient's integrity at risk, adopting an impulsive character, either for example in the field sexual, or excessive purchases without control, manic affect of optimistic vision that is accompanied by intermittent periods of irritability, and great self-image [10].

In the consultation guide of the diagnostic criteria of the American Psychiatric Association version 5 DSM-5 to specify depression, five or more of the following symptoms must be present; (a) present state of loss of mood, which lasts for an average of two weeks or more, coexisting loss of interest in areas where there was previously it, and of sexual appetite. 1: the state of sadness lasts during the space of the day, or most of it, and is steadily decayed during the course of the week, and can be expressed as a feeling of emptiness, loss of energy or will, which it is visible to other people. 2: participation in areas of social, work, academic, interpersonal functioning decreases, and interest and pleasure in participating in them. 3: there is a notable loss of weight, or its increase, an unintended change, accompanied by loss, to an increase in appetite respectively. 4: the person sleeps more than usual before the depression or has trouble falling asleep. 5: may be observed sluggishness in speech, language, psychomotor slowing, or agitation and a feeling of restlessness. 6: the person manifests feeling tired, or without the strength to carry out activities those they normally carried out before. 7: this state can be accompanied by self-reproach, criticism, or a punitive attitude and exaggerated judgment, sometimes reaching a delusional extreme. 8: the person reports difficulties in attending to details, and in turn, decreased ability to remember them. 9: ideas, plan or step may be presented to the act of self-injurious behavior. (b) these symptoms being significant enough to alter the normal functioning of the person, and cause deterioration in different areas. (c) It is not feasible to attribute these symptoms to a medical illness or other disorder that better explains them.

This same manual differentiates other disorders in the depressive category such as dysthymia or persistent depression, major depression, premestrual dysphoric disorder, substance-induced or medical condition. For its part, in the classification of mental and behavioral disorders, the Disease Classification Manual version 10 (ICD-10), issued by the World Health Organization and the Pan American Health Organization specifies two major types of depression, within a macro characterization of mood disorders: the depressive episode in its mild, moderate presentations, with or without psychotic symptoms, and others not typified, and the Depressive Disorder mild, moderate, severe recurrent, with and without psychotic symptoms, currently in remission. Establishing the following diagnostic guidelines; (a) alteration of functions such as concentration and memory. (b) loss of sense of self-efficacy. (c) guilt and ideas of uselessness. (d) vision of the pessimistic future. (e) ideation, accompanied or not by suicidal behavior, including parasuicidal acts, such as the conscious action in exceeding doses of medication. (f) impairment of the onset, course, or maintenance of sleep. (g) loss of appetite. The dysphoric mood tends to be consistent,

and sustained over the days, without much variation, followed or not by irritability, phobic, or obsessive concerns, such as the possibility of contracting diseases. Somatic symptoms, which can be observed by others are; (c) awakenings or shortened sleep. (e) agitation or psychomotor slowdown. (f) noticeable weight loss.

It is recognized in depression, a sequence that goes from acute symptoms, to recur over time, to a point where it is consolidated as a chronic disorder, with recurrent episodes, something that will happen to half of patients whose symptoms at some point they remitted completely, from this it can be deduced that the post-treatment relapse rate is high [11]. Symptoms can return in a period of six months or do so at a later time, considering that the patient enters "recurrence", if there is a return of symptoms after twelve months, in which case, said depressive episode is classified, not linked to the former [12].

BECK'S COGNITIVE MODEL

Beck concetualized depression as a perceptual framework, who's light preferably illuminated negative aspects, respect for oneself, others and the world, ignoring the positive qualities of life [13]. The depressed patient, in cognitive terms, distorts the input sensory and perceptual information, selectively filtering previously predicted data, disconnected from logical reasoning and in turn, lacking in evidence, composed of a discouraging generalized expectation, which together with cognitions are visual, graphic, verbal and attitudes, configure a scheme, fueled by false beliefs, not realistic, and not functional. Scheme composed of three blocks of structures, or pillars that together make up a triad of cognitive patterns whose objects are the self, experiences and the future [14,15].

The first pattern consolidates a self-concept determined by negative ratings product of selective, decontextualized abstractions, which maximize the aspects seen as negative, and minimize the positive ones.

The second pattern perceives the different events, events and situations as obstacles impossible to modify or face, in which the person is prevented from acting on the world and being able to change things in it, avoiding alternative solutions, until alternative perspectives or interpretations are ruled out. Facing the same facts. The third pattern of the triad is a vision of the future, of adverse events, inevitable frustrations and failures.

The reason why the continuous cycle of cognitions and affect of clinically pathological sadness is maintained or perpetuated is the dysfunction of the organizational system that gives structure to thought, at the level of the scheme that governs the basic functions, which once altered filters stimuli, selectively attends fragments of events, modifies, reconstructs facts and memorizes information from biases, which have acquired a stable, inflexible condition, which decodes all input data, which make any set of stimuli whose information and significance diverge from the triad, take the form of concepts previously installed and assimilated by this structure [16].

The cognitive model hypothetically postulates the existence of predisposing factors in the triggering of depression, among which are early experiences from which images, concepts, about the world, experiences seen in its general sense are extracted, as what can be expected of them, and about the self, that are specified, persisting latent during psycho-emotional development, until finally activating in circumstances that evoke the same ones that gave rise to the representations formed when adverse, hostile events took place or loss. These representations, in principle, survive time, reactivating with each experience that they manage to make similar to their content, associating affective states, which give a sense of certainty, to the early beliefs arising from negative events [17-20].

The bidirectional interaction of the maintenance of depression, in relation to the relationship with others, allows communication to become a process of mutual influence, in which the person organizes the experience in a way that accommodates the structure of schemes, predisposing the behaviors of others to confirm what is already held as a belief of which there is full certainty.

THEORY OF HELPLESSNESS LEARNED FROM SELIGMAN

Seligman, postulates as a crucial factor in the development of depression, the explanations and causal attributions that the person makes about the events that are not reinforcing, or carry a punishment, when people attribute the impossibility of obtaining an achievement, to factors that are intrinsic, stable, or inherent to them, fixed to the totality of the self, in such a way that they cannot be changed, and are perceived globally as powerless beings in the face of stressful situations or negative events that they face, arise in them, depressive symptoms, [21-23]. This attributional style about internal impossibilities or obstacles responsible for a performance seen as poor, and not achieving desirable goals, and the perception of a world over which no control can be exercised, is in terms of Seligman and Peterson, a sense of learned helplessness, which is, in turn, the main risk factor for the appearance of a depressive disorder [24].

LEWINSOHN'S BEHAVIORAL THEORY OF DEPRESSION

In the framework of a behavioral model of depression, Lewinsohn, proposed as a determining factor in its maintenance, a gradual loss of reinforcements, and inability to obtain positive consequences derived from their own actions, due to a poor repertoire behavior that leads to a low rate of reinforcement [25]. The depressed person generates few opportunities to be positively reinforced, which in turn, reduces the frequency of behaviors that could change this panorama, generating a visual circle. Instead of putting into practice actions that increase the probability of satisfaction and gratification, the person becomes increasingly discouraged, with a decrease in efforts and behaviors that would be more adaptive-, avoidance or escape behaviors [26]. Which lead to the loss of more sources of reinforcement belonging to different domains, in principle not connected with the initial loss

events that lead to biases in the processing of information and negative emotions [26,27].

REHM'S SELF-CONTROL THEORY

For his part, Rehm, addressed depression as a complex of symptoms linked to a dysfunction of self-regulatory processes, self-control, and self-management of behaviors, which are not conducive to positive reinforcers, by failing to achieve a effective manipulation, capable of modifying the environment and obtaining gratification from it [28]. Not carrying out the performance of evaluative and discriminating practices of dispositional, environmental, resource sets, available to achieve desirable goals, nor a realistic assessment of which objectives are achievable, and if instead, a predominantly externalizing perceptual anchor; towards contingent events, seen as random, agentless, outside the control radius, as causes of fortuitous gratifications, outside the margin of power that controls actions, regulates effort, and executes plans that make them possible. It is linked to the above, a failure in the management of self-reinforcement, which has been prevented from establishing; an adjustable and reasonable framework of objectives, evaluation of long-term consequences, which follow the sum of present behaviors, change of behaviors according to a greater effectiveness verified after the execution of these. The result of this is a repeated pattern of feedback from the environment, and stimuli that involve a negative, punishing, and frustrating character.

The person with depression, from the point of view of this model, is not aware of the pattern of behaviors in which they engage, nor which of them, being habitual and being automated, give rise to unforeseen consequences, and if they were, not knowing how to generate alternative responses that produce different results. Thus, it is not unusual, that high rates of punishment are combined with low rates of self-reinforcement. Both factors are linked to an immediate, non-prospective perception of obtaining the rewards provided sometimes yes and sometimes no, according to unknown and unstable configurations of the environment, added to unrealistic expectations and standards, in terms of their possibilities of achievement. The result is then translated into a cycle of attributions of causality and competition skewedly elaborated where the motivational reinforcers become external, and therefore fickle unconscious, and the causal attribution of failure is anchored in fixed terms to intrinsic or immovable capacities [29].

BRIEF CONCEPTUALIZATION OF COGNITIVE BEHAVIORAL THERAPY ABOUT TWO MODELS

Rational emotive therapy by albert ellis

According to Ellis; People pursue goals or purposes (G) such as staying alive, enjoying life, establishing and maintaining intimate relationships, etc... When pursuing these purposes, they face adverse events or experiences, which he calls activating events (A), which lead people to experience consequences (C) that lead to feelings that can be considered healthy and even useful, such as frustration, among others. Although the consequences can also impact people in an unhealthy and harmful way, causing destructive emotions and feelings such as depression, serious anxiety [30,31].

Faced with adverse events, people find certain ways to cope with them, be it by accepting them, trying to modify them or reacting to them in a defeatist and non-functional way. The way in which people face such activating events (A), will be determined by their beliefs about such event (A), the beliefs that people adopt may well be rational (RB) or irrational (IB) and according to their degree of rationality or irrationality they will experience feelings as well as functional and healthy behaviors or dysfunctional behaviors that will negatively affect their health [30].

Irrational beliefs are usually of an absolutist, dogmatic and rigid nature that make it difficult for the person to perform in their daily life, spoiling the person's possibilities of coping. Beliefs can be images, ideas, or cognitions that are at an almost unconscious level. REBT rational emotional-behavioral therapy seeks to elicit new life philosophies (E) in its clients that lead to more functional and healthy adaptive actions.

Using a complex of rational and emotional techniques such as, for example; questioning or rational dispute, the confrontation of irrational beliefs, Socratic dialogue, and many other techniques, all of them used under logical assumptions, and also empirically proven their effectiveness. The REBT tries to test the veracity of the imperative, resistant, rigid, generalized and absolutist beliefs of its clients, working on their beliefs (B) so that these when interacting with (A), do not reproduce together with actions and feelings, negative consequences that, at the same time, lead clients to aggravated and disturbed emotional states, as well as the reaffirmation of a dysfunctional belief system, which perpetuates the cycle of new unpleasant consequences.

Schema-focused therapy by Jeffrey young

For Young, the scheme is, in general terms, a concept of a cognitive nature that processes information, evaluates it but makes distortions in its evaluation, which therefore makes it vulnerable to the development of disturbances of a relational, emotional order and the appearance of behavioral disorders, derived from alterations in the logical structure of thought. The characteristic of the construction of a scheme resides in the autonomy achieved by the structure of thought, to create a world made of representations, parallel to the real one, through processes of selective attention of sensory stimuli, of sensitive memory traces and experiential material. Extracted from the latter, to confirm, later, the solidity of its creation. In short, the notion of schema has a place, as representation has the performative potentiality of assuming the place of the "thing", and the magical power of turning an interpretation into an absolute and unquestionable fact.

Cognitive behavioral therapy has to its credit a versatile and broad arsenal for the intervention of different types of psychosomatic, chronic pain, and psychiatric disorders, including

depression, with empirically validated support of its efficacy, under the postulate of distortions in the cognitive processing of information, as the basic core, which supports and in turn explains the etiology, the mechanism of depression and other disorders. Behind each altered manifestation of behavior and emotions, there is a dysfunction of the processes of thought, abstraction, selection, analysis and synthesis, which produces a cascade of adaptive and persistent thoughts. Once these cognitive processes are modulated, with a greater adjustment to reality, it becomes possible to mediate and moderate more functional and less distress-generating emotional and affective responses [14].

Proven evidence and contrasted evidence of CBT and pharmacotherapy

In meta-analysis studies, calculations of mean effect sizes, when comparisons are made between groups without treatment, control, with or without other types of specifications, associated with intervening variables such as concomitant medical disease, hypertension, or taking medications, have highlighted how complex it is to attribute the causality or attribution of change to a single factor. However, there has been evidence of greater effectiveness in the application of CBT than the mere hope of improvement or of receiving treatment at some point [31,32].

CBT has shown robustness of effect superior to other psychotherapy offers, when 78 controlled clinical trials were evaluated, with a sample size of 2765 patients, with controls that included placebo administration and a waiting list and moderately superior to antidepressant medication, taking self-registration measures, scales, that will assess mood, with the inter-test results being consistent. The effects of CBT are robust, sustained longer than drug therapy, when compared on a longitudinal time line [33-35].

However, the results of compared treatments for acute and severe depression, not in all cases have been favorable to CBT, in fact, the first trials with the use of control groups and the use of placebos (drugs with the absence of active principle) yielded Data that contradicted what was said in the previous lines, on the efficacy of CBT, indicated that it did not outperform interpersonal psychotherapy, antidepressant medication was more effective, and there were no statistical differences between the administration of a placebo and CBT. This was pointed out by the collaborative research program in the treatment of depression of the institute of mental health with a sample of 250 patients diagnosed with major depression, who received 16 weeks of therapy. Cognitive, concomitant to the use of an antidepressant drug, and placebo group. In general order, the reduction of symptoms was greater when psychotherapy and medication were applied, the difference between one and the other psychotherapy did not show significant differences, attributable to the clinical management of both contrasted. data that have subsequently been corrected using random regression models with more powerful statistical analyzes, which yielded more differences between the psychotherapies than those initially found, at the rate of one variable included initial severity of depressive symptoms and degree of deterioration [36,37]. There are no doubts about the study designs, and the rigor of their implementation in terms of issuing verdicts on the efficacy of psychotherapies, starting with the sample size, what so ideal was its application, if the ability of the therapist, training, competence and years of experience, and expert knowledge are taken into account [38,39]. When these variables are controlled in the studies, Subsequent trials have given CBT the same effectiveness as pharmacotherapy, in studies with more severely depressed patients [40-43].

when comparing CBT with a therapeutic regimen of antidepressants, both modalities carried out with a continuous duration of six months, found comparatively similar improvement rates, with CBT preserving its affects for longer, when Two years after the treatment, the patients were evaluated again, and it was also found that the withdrawal of the medication was correlated with a high relapse rate, which was not the case with CBT, results that could possibly be interpreted to the acquired skills to cope with everyday problems, learned strategies that largely counteract dysfunctional beliefs, and ultimately, the acquisition of a more adaptive way of perceiving stressful situations in life, and modulate one's own feelings, emotions, when it just begins to be glimpsed, the initial prodromal phases of a near relapse event.

CONCLUSION

Against this background, it is recognized in the pharmacotherapy of depression, a palliative scope, but not of sustained suppression, which entails the use of medication indefinitely or even for life. In this regard, CBT has proven to be more effective than medication, since it not only intervenes in the acute phase of depression, but also reduces the probability of recurrence and the risk of relapse, with a prolonged effect over time, after its cessation, and providing the patient with mechanisms to prevent future episodes and how to deal with them [44]. Thus, the impacts of CBT, being long-lasting, beyond the end of therapy, decrease the number, frequency and duration of relapse episodes [45-63].

DECLARATION OF INTERESTS

The authors declare that they have no financial interests or personal relationships that may have influenced the work reported in this document.

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